June 24, 2003

MDR Tracking #: M2-03-1050-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a 59-year-old gentleman, was involved in repetitive pushing and twisting situations on the job that resulted in right lower extremity pain on ___. An MRI was consistent with an L5/S1 herniated disc. He subsequently underwent physical therapy and epidural steroid injections. On 9/12/02, for a condition of lumbar spinal stenosis and lateral recess stenosis he ultimately underwent a laminectomy and facetectomy at right L4/5 and L5/S1 with posterior lateral fusion at L4/5 and L5/S1 with autologous bone and instrumentation, as well as posterior lumbar interbody fusion at the level of L5/S1.

When seen in follow-up on the date of 1/13/03, this patient was having some hip pain but no sciatic pain. Consideration was being given to facet injections at that point. When seen by ___ on 1/23/03 he was complaining of low back pain and numbness in the right leg. Plains x-rays performed in October of 2002 were reviewed at that time, and it was recommended that he undergo fact injections above the level of the fusion and SI joint injections below the level of the fusion, as well as an EMG study of the right lower extremity to quantify nerve damage vs. reinnervation.

REQUESTED SERVICE

A facet injection, SI joint injection and EMG are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Treatment guidelines and care standards would indicate that in the absence of sophisticated neuroimaging studies postoperatively, such as MRI and/or CT scan, it is not prudent or of high yield to perform "blind" facet and sacroiliac joint injections. The same care standards and treatment guidelines would indicate that an EMG study at the present time as per the discussion of ___ would not alter the plan of management and therefore is as well not medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).